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PHYSICIAN-HOSPITAL RELATIONS*

ELMER HESS, M.D.

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A NUMBER of years ago, there were many resolutions sent to the House of Delegates concerning the practice of medicine by our Hospitals. The practice was condemned, and the House of Delegates was asked to do something about the situation. Nothing was ever done. Due to the insistence of the Anaesthesiologists, Pathologists, and Radiologists, something seemed to have to be done about this practice, and I became the goat because I was made the Chairman of a special committee of the Board of Trustees of the American Medical Association to study the problem and report back to the Trustees a method for its solution.

On that committee was Walter Phippen of Massachusetts, John Cline of California, Hamilton of Illinois, and Vest of West Virginia, with myself as Chairman. We studied everything that had been turned over to the House of Delegates, and after a preliminary meeting, we came to the conclusion that resolutions could be passed until Hell froze over, but unless teeth were put into these resolutions, they would be of no value. We decided that the first thing to do was to have our Legal Department at the American Medical Association study the individual laws of every State in the Union with particular emphasis as to what constituted the practice of medicine. We came up with some very astounding information, and found that in every State in the Union, with some exceptions, that the Corporate Practice of Medicine was illegal. I believe that Maryland was the only State in which the complete Corporate Practice of Medicine was legal and that was due to the fact that Johns Hopkins had the Maryland Legislature pass a law making it possible for Johns Hopkins University and Hospital to hire physicians at full-time salaries and charge fees for their services. The surplus was used for the maintenance of the hospital and medical school. To the best of my knowledge, Maryland is the only state in the Union where that law today is in force.

It seems strange to me when I stop and think about all of the people to whom we have listened as a committee, all of the witnesses we have heard, all of the legislators who have consulted with us — it seems strange to me that there is so much apparent animosity between hospital administrators and members of the medical profession. As a matter of fact, in my own State in the last few days, I have been personally attacked in the bulletin of the Pennsylvania Hospital Association as being an instigator — if you please — of rules and regulations which are impractical and which are meant to destroy the American Voluntary Hospital system and bring upon both the hospitals and the American Medical Association Compulsory Sickness Insurance — believe it or not!

Background Data

Let us get a little more background on this most important subject. A number of years ago, the American Hospital Association, the American College of Surgeons, and committees from the American Medical Association — including pathologists, roentgenologists, and anaesthesiologists met to study the problem. They drew up rules and regulations, and they were based on one thing and that was — that all problems concerning both the hospitals and the profession must be solved at the local level, depending upon local conditions, and the motivating objective behind the solving of these problems must be the best quality of medical service possible to render to the public.

You would think that rules and regulations of that character signed by responsible people would be respected. This committee was headed by Dr. Robin Buerki who today is Vice-President of the University of Pennsylvania in Charge of Medical Affairs. He is a doctor and was superintendent of the University of Pennsylvania Hospital in Philadelphia when these rules and regulations were set up.

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* Presented at the Midwinter Meeting of the Rhode Island Medical Society, at Woonsocket, R. I., December 13, 1950.

Nothing happened. The same old fight, the same old cry of exploitation by hospitals and doctors, and no attempt was made in any way to help solve the problem by sitting down around a table and trying to arrive at a proper decision. As a result of these things which have happened, your committee — because after all, any committee of the American Medical Association is a committee of the Rhode Island Medical Association — your committee came to the conclusion that nobody wanted to solve these problems, that we were dealing on both sides with some pretty selfish people, or at least, people who did not want to understand or help solve these problems.

Then, a number of years ago, I was appointed a director of AMCP representing the Council on Medical Service of the American Medical Association. This was a combined directorate of both Blue Shield and Blue Cross, and we attempted to solve this and many other problems. We recognized that since Blue Shield and Blue Cross were the only weapons we had against Compulsory Medicine, that it was imperative not to disturb the relationships which already existed where medical services were furnished by Blue Cross. We hoped that Blue Shield and Blue Cross would take care of this in their joint relationships, but both Blue Shield and Blue Cross and the American Medical Association became involved in what seemed to be an irreconcilable controversy on some fundamental principles.

Insurance Company Participation

The American Medical Association has always stood for principles. We are willing to compromise everything but our fundamental principles; the American Medical Association felt that it could not oppose the commercial companies who finally came into the field. I might tell you a little about the background of the commercial companies in this Voluntary Sickness Insurance movement. Over ten years ago, I sat in New York City with Roscoe Sensenich and others in a meeting with several of the officers of the largest insurance companies in the world. This was in the early days of Blue Cross and when we were beginning to talk about Blue Shield. At this meeting, the presidents of those companies told us, "We have no actuarial figures. We are going to let the doctors plow the field and plant the seed and we will reap the harvest, if there is any." We tried to show them that they had a six billion dollar business for the asking. They were afraid of it, but now they are in. I am enough of a heretic to say that all the money the doctors have spent on Blue Shield and in support of Blue Cross, if both of them died tomorrow and the commercial companies took over and would do a good job that would have the approval of the American Medical Association, that every dollar has been well spent, because after all, we are not business people — not insurance people — but we have a backlog of well-trained insurance people that commercial companies could use. These men would help the commercial companies do a good job.

I understand that in the State of Rhode Island you have commercial company support. It doesn't matter who supplies voluntary insurance so long as it is supplied for the benefit of the people. I, for one, am a firm believer in letting shoemakers make shoes and a plumber do the plumbing. However, I believe that in those States where there is Blue Shield we should, as a profession, give it full support — because Blue Shield is our insurance program, and wherever possible we should work for Blue Shield.

In writing the Hess Report, because that is what it became known as, we incorporated this plea for all the insurance companies, both commercial and Blue Shield and Blue Cross, to put into the medical policy medical services, and into the hospital policy hospital services.

Hospital Standardization

Some other things occurred about this time. The American Medical Association, ladies and gentlemen, has to represent the so-called little fellow on the crossroads and the so-called big man in the Ivory Tower. It has to protect the public and it has to protect every doctor regardless of where he lives, what his training is, what his ability is, and wherever he may practice. You would think that the American College of Surgeons — and I happen to be a member of the Board of Governors of this organization — would be thoroughly cooperative with the American Medical Association. Unfortunately, this has not always been true, and a short time ago, the American College of Surgeons was reported — mind you, I say *was reported* as being willing to turn over hospital examination for approval to the American Hospital Association. That is not the truth. What happened is this — the American College of Surgeons has investigated and approved hospitals for their surgical proficiency for years. The American Medical Association has investigated and approved hospitals for their ability to train interns and residents and for their general proficiency — two completely separate functions, but these functions do dovetail. One function is special; the other is general. Now, the American Medical Association has been spending over $250,000.00 a year for the inspection of our hospitals. The American College of Surgeons has been spending over $60,000.00 a year to inspect and approve hospitals as places where good surgeons are operating properly, and State Boards of Medical Licensure are inspecting hospitals for the purpose of seeing that they are good places for young interns to train. Now, what happened?

The American Hospital Association found out that the American College of Surgeons was considering a revamping of their hospital inspections for approval, and so in Atlantic City a short time ago, the American Hospital Association jumped the gun and said that the American College of Surgeons was going to disband its investigation of hospitals and they, the American Hospital Association, were going to take over lock, stock, and barrel. This was the report, at least, freely circulated among physicians. Officers of the American Medical Association took off for Atlantic City in a hurry to find out if this report were true, and if it were true, to try and stop the American Hospital Association from approving itself. As a result of the meetings in Chicago and Atlantic City, the American Medical Association, the American Hospital Association, and the American College of Surgeons are cooperating in an endeavor to do a bang-up, overall job of hospital investigation and approval. You can see the differences that existed. They are there, and they all have not been eliminated yet. All of these various controversies which we knew were going on had something to do with the rewriting of the so-called Hess Report which has to do with the relationship between our physicians and our hospitals.

When the final Hess Report was written, we had two new men on our committee: Dr. Barnett who is superintendent of the Harper Hospital in Detroit and high brass in the American Hospital Association and Dr. Johnson, also of Detroit. After these men were appointed to the committee, the final report was written. It was sent to the Board of Trustees of the American Medical Association, approved by them, and referred to the House of Delegates. Here it was referred to a reference committee which changed some of the report — and I think weakened it. It was then sent back to the House of Delegates and was unanimously approved.

Analysis of Hess Report

Now, what does the Hess Report say? It says simply three things. First, that it is illegal for any corporation to practice medicine except as previously noted; second, that it is unethical for any physician to share his fee secretly with any other doctor or corporation; and third, that all of these problems should and must be solved at the local level for the benefit of the public. It says somewhere in your code of ethics — I cannot tell you the exact line at the moment — that that which is for the best interests of the public is ethical. This gives you great leeway.

The report also suggests ways and means to settle controversies from the County level to the American Medical Association level.

Now, I would not protect any doctor in any complaint he had against his hospital if it were merely for the purpose of protecting his pocketbook. I have practiced medicine for forty years. I have taken care of rich and poor alike, and I have the unusual experience of never yet setting any patient's fee. I have permitted patients to set their own fees and I have no complaints about my income. I am completely satisfied that the vast majority of the American people are honest and they will pay a fee they can afford to pay if they are rendered good service and if they were not honest, there is not one of us in this room who could earn his living.

I am here to protect the doctor's principles and that is *the only thing that counts* — it is the thing that makes us members of a profession instead of being business men. All we have to give is service, and when we put the dollar ahead of the service, then we no longer are worthy of the name "physician" — I care not whether you are a professor at Harvard or a little fellow at the crossroads. Our first job is to alleviate human suffering and that is more important than our second job which is to save life. That reminds me of a story. A female doctor had just graduated from medical school. On her way home, there was a railroad wreck in which a poor guy had his leg mangled. He was dragged up to the express car, and a query went through the train, "Is there a doctor present?" The girl replied that she was a doctor. When she got off the train and was telling her father about her experience, he asked, "What did you do for him?" She said, "I held his hand." He then asked her if she had any morphine in her case, and if so, why hadn't she given him some to relieve his pain. Her answer was, "I had no way in which to sterilize my hypo needle." The father replied, "What difference did it make if you used an unsterile needle? He was going to die anyway, and you would have relieved his pain." Do you understand what I mean?

Our third job is to tell others how to accomplish the first two so we may all profit from our experience. Our last job is to get a fee for service. I don't like to call it a fee; I like to call it an honorarium because there is not a man in this room who would not care for Mrs. O'Grady and her baby if she did not have a cent, and charge Mrs. Gotrocks $25.00, for a call if the service rendered was worth that amount.

What is the Solution?

Now, how should this entire problem between the hospitals and the various medical groups be solved? There is only one place it can be solved and that is here — by the doctors who practice here and the hospital administrators here. Problems

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arising in Providence should be solved in Providence.

Let us forget the hospital administrator for a moment. He is trying to hold down a job. Sometimes, he does not seem altogether fair, but I know x-ray men who sign contracts and then refuse to live up to them. I know hospitals that also sign contracts on the same basis. Every voluntary hospital has a Board of Trustees or Managers who are composed of hard-headed business men and bankers in your community, and these men are sensible. If you can go before these men and show them that they are not doing right and that you are willing to compromise everything but fundamental principles, you cannot tell me that they will not see the light, because their hospital is worthless without you and you are worthless without them.

These problems must be solved at the local level between men of good will, men who are honest, men who are sincere, men who are trying to render one thing — service to the public — and if your Board of Trustees is so unreasonable as to fail to see that, then the quicker you get away from that hospital, the better off you are going to be. The hospital will "play ball" with you if you can convince them that the things you request are fundamentally sound. You have to have intestinal fortitude and you have got to be right. If you are honest and right, these men will listen to you.

The doctor has many duties. He has a duty to his profession. He also has a duty to the hospital. What is this duty? Give it the very best service you can give it. When it goes in the hole, try to help it out. What do I mean by that? The only reason the average hospital does not get along with doctors on its staff is because we have no staff representatives on the Board of Trustees, and some of the Boards of Trustees would find we are pretty good business men. We might be consulted before raising room rents; we might have some other ideas about financing the hospital. I think it is abominable when a patient cannot get a room for less than $12.00 a day for an appendectomy or hysterectomy, or what have you, and I think more of us should be on the Boards of Trustees and help to solve some of these problems.

Let us get accountings from our hospitals. Let us find out if they can save money here and there. Let us find out whether an administrator is doing a real job or if he is putting it over on the Board of Trustees. We have that responsibility to the community.

We also have a duty as citizens. In the last presidential election in 1948 — there are two hundred doctors in my county — our total registration was about thirty. At the last election, 98% of our doctors and their wives were registered and their children old enough to vote were registered, and the 98% voted. I very distinctly object to being ruled by minorities.

Let us look at the last presidential election, if you will, for just one moment. I believe that there are approximately ninety million people in this country who are eligible to vote. Think of that! I believe that approximately fifty-two million of them are registered. Half of the registered number of voters voted, and that means the ruling party which got the slim majority of votes — 51 or 52% — constituted less than 15% of the potential voters of this country. If the country wants to go socialistic, I am for it as long as the majority of people vote it, but I will be darned if I want to be ruled in a socialistic, totalitarian country with 15% of the people calling the terms.

We have not met our obligations, ladies and gentlemen. Every adult in this room should be registered in the party of his choice, I care not whether democrat, republican, or socialist. I think the latter party is next to communism. You have not, however, done your duty as citizens unless you register, and you cannot be a good doctor and not be a good citizen.

I would like to close with just one thought, if I might. We are going to solve this hospital-doctor relationship. The Hess Committee has made its report and I, in particular, have been damned. That is all right with me. I welcome honest criticism, constructive criticism and I pay no attention to the criticism of the hypocrite, or to that of a self-seeker.

I want to say to you that until we awaken this country to the spiritual values that go with the practice of medicine, we are licked. I do not ask you to be a Catholic or Protestant or Jew or Baptist or Methodist, or Mohammedan, but medicine without spiritual values is not medicine, and when you add these values to the other assets you and I have, when we do believe in something more than the pay, when we will put aside our jealousy toward each other and present a united front, nobody can lick us.

Look at November 7. Gentlemen, the future of America, in my opinion, lies in the courage, the tenacity, the goodness of heart, the willingness to sacrifice, and the greatness of soul of this medical profession.

INFECTIOUS HEPATITIS*

Report of a Case Complicating Pregnancy

ELIHU S. WING, JR., M.D. AND LEONARD SUTTON, M.D.

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ACUTE YELLOW ATROPHY of the liver is an infrequent, serious complication of pregnancy. The first case report was cited by Kerkring in 1706.[1] An incidence of approximately ten cases per 70,000 pregnancies has been reported.[2] Recently, a case of infectious hepatitis complicating pregnancy culminating in severe liver failure — perhaps acute yellow atrophy — was studied at the Rhode Island Hospital. And because of the unusual complications which this patient demonstrated, it is desired to add this case to the rather scant literature.

Case Report

This patient was a 23-year-old seven months' pregnant white woman admitted to the Rhode Island Hospital with the complaint of weakness and nausea associated with anorexia and progressive jaundice of two weeks' duration. A review of her past history disclosed no serious illnesses or operations. Although a previous pregnancy had terminated in a miscarriage one year prior to entry, her present pregnancy had apparently progressed without any significant abnormalities. She had been under the care of a physician who at no time administered injections or withdrew blood specimens.

Two weeks prior to entry she noted the onset of mild scleral and cutaneous jaundice, fatigue, generalized malaise, weakness, loss of appetite and nausea. She also noted unusual "nervousness," tremors, and perspiration upon awakening in the morning. She denied fever or chills. Her urine became a deep amber and her stools changed to a light gray color. Because of the progression of symptomatology she was referred to the hospital for diagnostic study and therapy.

Physical Examination — B.P. 110/50, temperature 98.6, pulse 90, respirations 20.

She was a well-developed, well-nourished, white woman in no particularly acute distress. There was definite scleral and cutaneous icterus. The significant physical findings were associated with the abdomen, which was protuberant, soft, and non-tender. The uterus was enlarged and consistent with a seven months' pregnancy. A non-tender liver edge was palpable two centimeters below the right costal margin. The spleen was not palpable. The heart and lungs were not remarkable. There was no edema of the extremities. Our impression was that of infectious hepatitis associated with a normal seven months' pregnancy.

Laboratory Data — RBC 3.9 million/cu.mm., hemoglobin 12.5 gm./100 cc., WBC 12,900/cu.mm. with 81% polymorphonuclears, 17% lymphocytes, and 2% monocytes. BUN was 5 mgm./100 cc., glucose 38 mgm./100 cc. (normal 60-100 mgm./100 cc.), thymol turbidity 16, icterus index 78, total protein 5.8 gm./100 cc. (albumin 2.8 gm./100 cc.), prothrombin activity 48% of normal. Blood Hinton negative. Urine: Color amber, specific gravity 1.012, protein 1+, sugar negative, bile positive, urobilinogen .025 mgm.%. Clotting time (Lee-White) 8 minutes, and bleeding time (Duke) 5 minutes. Rumpel-Leeds test was within normal limits. The chest x-ray was interpreted as showing normal lung fields and cardiac silhouette.

Hospital Course: The patient was confined to bed with a dietary schedule consisting of a high protein, high carbohydrate and low fat intake. Supplementary vitamins, including the B, C, and K group were administered.

Her first four days were uneventful with appetite gradually regained. On the 6th hospital day she became nauseated and vomited several times. Several hours later typical labor ensued with the subsequent delivery of a viable, non-icteric, three pound four ounce female infant. Following her delivery she was placed on a regimen of ergotrate in apparently adequate therapeutic dosages. Her blood loss was minimal. The immediate postpartum course was uneventful.

Two days postpartum she again experienced nausea and vomiting, became restless and apprehensive, and complained of lower abdominal cramps. Within several hours she became progressively lethargic and lapsed into coma. Examination at that time disclosed an acutely ill woman with stertorous respirations, a blood pressure of 114/70,

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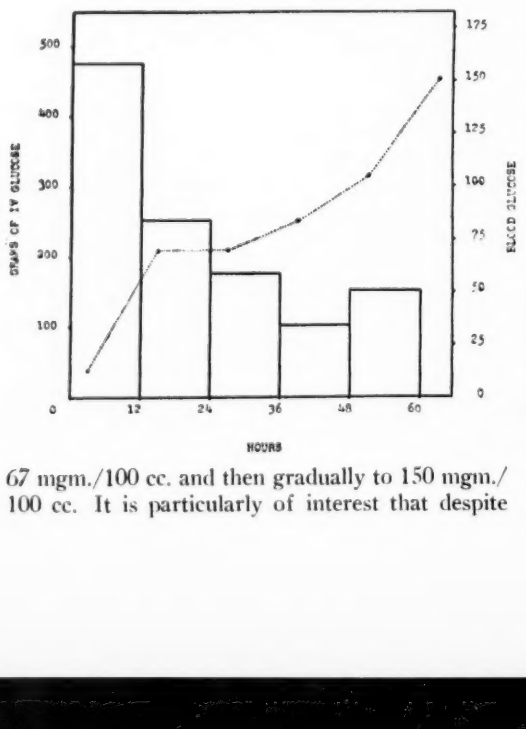
* Presented before the Providence Medical Association, at Providence, R. I., November 6, 1950.

pulse 132 and temperature 99 degrees. Her skin was icteric and dry with a non-pitting puffiness about the face and extremities. A fetid breath was evident. There were frequent convulsive movements of all extremities. The corneal reflexes were absent. The abdomen was soft. The liver edge was no longer palpable, with a markedly diminished area of liver dullness as demonstrated by percussion. Her WBC was 43,600/cu.mm with 90% polymorphonuclear cells. The blood glucose was 12 mgm./100 cc. with a BUN of 9 mgm./100 cc.

In the light of these dramatic changes, it was our impression that she had lapsed into acute hepatic insufficiency. To combat the marked hypoglycemia and collapse, 475 grams of glucose and 500 cc. of whole blood were administered via the femoral vein within a twelve hour period. Within two hours the patient could be aroused and answered questions. Additional fluids administered during the subsequent twenty-four hour period consisted of whole blood, plasma, Ringer's lactate solution, and a continuous intravenous infusion of 5% dextrose in saline. Twelve hours after the onset of her acute crisis, her laboratory studies disclosed the following: RBC 3.05 million/cu.mm., hemoglobin 9.5 gm./100 cc., WBC 49,600/cu.mm. with 74% polymorphonuclears, 17% lymphocytes, 8% monocytes, 1% eosinophil. Total protein 4.8 gm./100 cc. (albumin 2.2 gm./100 cc.), prothrombin activity 55% of normal, cholesterol 116 mgm./100 cc., thymol turbidity 9, and blood glucose of 67 mgm./100 cc.

A total of 725 grams of glucose was administered within the first twenty-four hours of therapy. As shown in figure 1, the blood sugar rose at first to

FIGURE I



67 mgm./100 cc. and then gradually to 150 mgm./100 cc. It is particularly of interest that despite the large quantities of glucose, her blood sugar did not rise to higher levels. Throughout the period of hypertonic glucose administration her urines were virtually free of sugar. Intravenous fluids were discontinued at the end of three days, at which time a high carbohydrate liquid diet could be tolerated. Multivitamins and crude liver extract were administered for empirical reasons alone.

Her appetite returned and was accompanied by a sense of well being. Her facial puffiness gradually disappeared with reduction of the icterus. By the 36th hospital day the area of liver dullness had increased and indicated a return to normal. Repeated blood chemistries disclosed progressive improvement, as evidenced by a total protein of 7.7 gms., albumin 3.8 gms., thymol turbidity 9, icterus index 13, BUN 12 mgm./100 cc., glucose 69 mgm./100 cc., and prothrombin activity of 100% of normal. The patient was discharged on the 60th hospital day after a two week period of normalcy demonstrated by repeated clinical and laboratory examinations. She has been followed frequently over the past nine months and is in good health.

Discussion

Zondek reported 29 cases of infectious hepatitis in pregnancy and classified them into three categories: (1) the non-icteric group with only mild liver impairment, (2) those instances of severe hepatitis with a moderate degree of hepatic impairment, and (3) those cases developing acute yellow atrophy.[3]

The early stages of yellow atrophy may simulate infectious hepatitis with anorexia, nausea, vomiting, diarrhea, and generalized abdominal pain. The patient becomes progressively ill with prostration, headache, restlessness, photophobia, incontinence and lethargy. If unrelieved, she may lapse into convulsions, stupor and coma. Liver size is markedly reduced. Edema of the extremities may be noted. The breath has been characterized as "mouse-like." Oliguria and anuria may terminate the process. The pathology is obviously one of fulminating generalized hepatic destruction.

Briefly, the significant laboratory findings are those of a moderate anemia and leukocytosis. The icterus index is elevated with reduction of blood sugar, cholesterol, and prothrombin activities. The urine is positive for bile with a moderate degree of urobilinogenuria. The amino acids, leucine, and tyrosine, may be demonstrated in the urine.[4]

Treatment: A high carbohydrate diet may be life saving in both clinical and experimental treatment of acute liver disease.[5] Soskin has repeatedly stressed the value of a high level of liver glycogen in the protection of the liver against acute disease.[6] With this in mind large quantities of carbohydrate should be administered without reserve in the pres-

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THE PROVIDENCE MEDICAL ASSOCIATION — 1950*

Presidential Address

FRANK W. DIMMITT, M.D.

The Author. *Frank W. Dimmitt, M.D., President, 1950, The Providence Medical Association.*

A YEAR AGO Dr. Ubaldo E. Zambarano was inducted into the presidency of the Providence Medical Association. It was the hope of all of us that his health would improve to permit active participation in our affairs and that he would be with us tonight. His death on May twenty-ninth after a long illness was a great loss not only to our membership but to the entire medical profession of Rhode Island. He was never able to join with us physically at our meetings during the first part of the year, but he was ever with us in spirit, and his advice and counsel were of great assistance to me as I carried on for him, and when I subsequently succeeded him as your President.

Dr. Zambarano's achievements have been set forth in detail in our records and in public tributes that are far more eloquent than any I might repeat tonight. I would ask, however, that all present now stand for a minute of silent prayer in memory of Dr. Zambarano.

Development of Medical Bureau

As the largest district medical society in the state, the task of carrying forward much of the work of the State Medical Society programs has fallen upon the shoulders of our members. That is a natural situation as the result of the location of our medical population. But it makes it difficult for your President to fairly evaluate the work of the Providence Medical Association during the year without, indirectly at least, taking some credit for our membership for the outstanding statewide programs. For examples, the cancer program with its annual conference for physicians is guided by a past President of our Association, Dr. George W. Waterman, while the diabetes detection campaign, now in its second year of activity, has benefited from the leadership of our incoming president, Dr. Louis I. Kramer.

So also with the development of Physicians' Service, of a statewide air pollution program as an outgrowth of the work done in Providence, of the postgraduate education work, the RHODE ISLAND MEDICAL JOURNAL, and many other activities in which Providence physicians give willingly of their time and energies.

There are, however, several activities that have been developed by your Association during the year that warrant review and commendation.

Foremost is the Medical Bureau of the Association, now the largest medical society sponsored and controlled secretarial telephone exchange in New England, and, I believe the second largest in the East.

The history of this Bureau is familiar to most of you. Committees studied the problem and planned the formation of the service twice, only to be balked by war and later by scarcity of available materials. On September 1, 1949, however, the Bureau was activated and its successful operation ever since for the medical profession, and more particularly for the general public, is probably without parallel in the country.

We would indeed be selfish as we view the splendid development and operation of our own telephone exchange if we did not pay ample tribute to the committees that were responsible, and in particular to Dr. John G. Walsh, a past President of this Association whose untiring zeal and enthusiastic work for the Bureau has made it a model for the country at large.

From a three-position board with five operators and a supervisor, the Bureau has within the space of one year expanded to a four-position control panel handling 12,000 to 13,000 calls a week through the efficient services of nine trained operators and a supervisor. I am sure that I do not have to comment on the service of this Bureau to the 288 physicians who support it.

Emergency Call Service

The medical profession in general, including our members, has been criticized for inadequate coverage of emergency night calls. To cope with this situation your Medical Bureau has undertaken the Herculean task of answering emergency calls referred to them night or day. In its first month of existence the Bureau answered 60 emergency

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* Presented at the 104th Annual Meeting of the Providence Medical Association, at Providence, R. I., January 8, 1951.

calls. Last month 217 calls were answered and in the past year a total of 2,104 calls resulted in the reaching of a physician in every instance to handle the emergency. Not all were true medical emergencies. The anxiety of a family too often creates a state of emergency as regards the patient.

You are all aware of the questionnaires that have been directed to you asking that you volunteer for emergency calls. Many of you have responded. To you the Profession throughout the State is indebted, for you have not only accepted the challenge made to Medicine, but you have also performed a community service regardless of whether you were compensated for your labor. While we are proud of this year's record, we must all recognize the growing responsibility that this work places upon us. I urge each one of you to accept your share of emergency call work so that the burden may not fall upon a few.

Possible Expansion of Bureau

The successful operation of our Bureau has shown how well a professionally-owned and operated agency can work. Might it not be advisable to explore the possibility of establishing a credit and collection bureau for the mutual benefit of the public and profession? In some localities such a service has aided patients in budgeting for payment of medical expenses, both contemplated and already incurred. The medical library is centrally located and not inconvenient to the general public. Creation of such a credit and collection service would not require much office space at the start. Its contribution to the development of the medical economic program begun with the Telephone Bureau is well worth considering.

Disaster Planning

Overshadowing all problems of today is that of the unsettled world situation. It is not a happy thought that we now find our Association and the State Medical Society establishing committees for medical defense and for the procurement of medical personnel for the Armed Forces. The statesmen may debate, and legislators on national, state, and municipal levels may discuss what steps are to be taken if the situation ends in war, but for the medical profession the need for organization for disaster is ever present whether such possible disaster is military or civil in nature.

Your Association created within the past year a Disaster Committee which has already initiated actively plans for emergency defense or civil disaster. A disaster plan for hospitals has been adopted, and has been submitted to every hospital in the area, with the request that the plan, in substance at least, be adapted to meet local conditions. Ours will primarily be the task of providing medical personnel, and we have approached the problem from that point of view.

Once each hospital has formed its disaster unit, utilizing such members of its staff as may be needed, all remaining physicians unassigned to hospitals or to Red Cross disaster units or similar groups will be listed for disaster service on call from the Medical Bureau. By such procedure it is our hope that every member of the Association who is available, and physically able, will be prepared to take his place where most needed in the event of a disaster.

We hope that the threat of war may be completely dissipated in the coming months; but we recognize the possibility of civil disaster at all times, and therefore our planning now will be towards a permanent organization.

Support of Medical Programs

The threat of socialized medicine seems somewhat abated at present. The recent November elections repudiate plans for the welfare state. The American Medical Association program for education directed to the public has aided, probably in large measure, in attaining the present situation. Certainly the A. M. A. effort needs and merits the support of all of us. It is a pleasure to note that our new United States Senator from Rhode Island has a sound and positive viewpoint in opposition to socialization.

There will be need through the coming year for the help of every member of the Association in carrying forward our work and that of the Rhode Island Medical Society. I call upon you to give that assistance to your new president and the slate of officers you will name tonight.

For the outgoing officers, particularly myself, I thank all the committees, our executive secretary, Mr. John E. Farrell, and those members whose individual counsel has brought this one-hundred and third year of the Providence Medical Association to a successful conclusion.

THE FIRST YEAR OF PHYSICIANS SERVICE

—Remarks of Joseph C. O'Connell, M.D., President of the Rhode Island Medical Society Physicians Service, at the 2nd Annual Meeting of the Corporation, at Providence, January 17, 1951—

ONE YEAR AGO we assembled here for the first meeting of the Corporation of the then newly-organized Rhode Island Medical Society Physicians Service. Tonight we assemble for our second Corporation meeting, and it is a time for review of our accomplishments of the past year.

In our first year of operation we enrolled 769 groups representing 119,055 subscribers. We had one of the lowest, if not the lowest, operating expense of any similar plan in the country — 7.5%. The Plan had earned subscriptions totalling $583,-192.88. Of this amount $380,283.50 was paid out in benefits for services rendered to subscribers; $43,732.22 was utilized for operating expenses, and $159,177.16 was allocated as reserves.

Such is the brief story of the enrollment and financial status of Physicians Service during its first twelve months of operation. The complete reports are available to you in the detailed statistics prepared by the executive director, his staff, and the treasurer. But the mere recital of figures, however favorable, does not begin to tell the story behind the first year of our operation.

The real story is the story of Service that has been rendered to the people of Rhode Island—Service that has been recognized to a great extent by the public as is evidenced by the enrollment in the program.

As President of the Corporation, and as a past President of the Rhode Island Medical Society, I salute the physicians of this State for their great service to all citizens evidenced by their participating as active physicians in the plan. Seven hundred and three physicians responded willingly, although they knew that the schedule of indemnities drafted some seven years ago was in a great many instances less compensation than that to which they were entitled due to the rising cost of living during the intervening period, and the consequent rise in incomes for all working groups.

Not only did our physicians agree to participate, they took an active part in promoting the Service on every occasion. No other group, private or public, has presented to the people of this State the community service that has been offered by the medical profession. No other organization, service, or group of citizens has come forward as we have and has offered to render its services in the best manner possible at a reduced compensation for persons in low and middle income classification.

Service made our plan the success it has been in its first year, and a service of which few are aware, and which few appreciate to the full, is that which was rendered by the non-medical members of our board of directors for whose sound thinking and planning and generous allowance of their time and energies the Society is truly indebted. We are also deeply appreciative of the spendid work of the executive director, Mr. Stanley H. Saunders, his fine administrative staff, and those of our colleagues who have served willingly and well on the joint operations, executive, professional advisory, and finance committees.

The public response has been influenced in great measure by the support of industrial leaders who have recognized in our Plan the opportunity to encourage the voluntary, American way of budgeting for medical needs. These industrial leaders, as well as labor heads, have recognized in our proposal benefits far greater than any that could ever accrue from any government managed or controlled tax plan to cope with expenses for medical needs. We recognize our responsibility to make our program a strong bulwark against the socialization of this nation. We will not shirk that responsibility.

As we look to the future we would like to see the continuance of our first year of phenomenal growth. But the sky is not too clear, and the clouds of trouble are too familiar to all of you who are closely allied with our effort. We will continue our efforts to improve our Service, and we will look forward to the day when radiological benefits, and additional medical benefits may be included in our contracts. Within the year it is our hope that we may see our way clear to offer direct enrollment to assist all those persons in small employments, and those persons not employed. How soon we can expand our Service to allow such arrangements will depend on actuarial data now being compiled.

As I have already stated, the participating physicians agreed to support the program even though disagreeing with the somewhat outdated schedule

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TETANUS

Report of a Case

CYRIL BELLAVANCE, M.D.

The Author. *Cyril Bellavance, M.D., Resident, Rhode Island Hospital.*

THE PATIENT was a 14-year-old, white, single female who was first seen in the Accident Room of the Rhode Island Hospital on July 28, 1950. She had a compound, complete transverse fracture across the basilar portion of the diaphysis of the terminal phalanx of the left middle finger. She had received this lesion shortly before admission while playing on the lawn with some friends, one of whom had stepped on her finger while it was on the ground.

The lesion was cleaned and irrigated with 600 to 1,000 cc. of sterile saline, manipulated, dressed and immobilized. The house officers, who had treated the case, left the Accident Room to see the check-up x-rays and, when they returned, found that the patient had left the hospital. An order was written for the patient to receive tetanus antitoxin therapy and penicillin for three days on her return to the Fracture Clinic the following day. She was seen at that time and through some misunderstanding, penicillin therapy was given, but tetanus antitoxin therapy was not.

This 14-year-old girl was next seen on August 3rd, 1950 when she walked into the Accident Room with her parents stating that she had noted difficulty opening her jaws since the morning of that day, which was six days following her injury. Otherwise, she was asymptomatic. She had no pain, fever, chills or gastro-intestinal symptoms.

Physical examination, at the time of admission, revealed the blood pressure to be 125/76, pulse 120, respirations 20, and temperature 100° (r). The patient was a well-developed and well-nourished, adolescent white female lying in bed in no acute distress. At examination, she was unable to open her mouth. There was only room for a throat stick between her teeth. When an attempt was made to open her mouth, pain was noted. She had no stiffness of her neck. The physical examination was otherwise negative except for the wound of the left middle finger.

The patient was skin tested prior to tetanus antitoxin therapy. The total dosage of tetanus antitoxin given was 400,000 units. This was completed in the first 43 hours following admission and was given in divided doses, intravenously and intramuscularly. No intrathecal tetanus antitoxin was given. Shortly after admission, the patient was taken to the Operating Room and, under anesthesia, the wound was examined. It was clean and there was no evidence of local infection. Cultures were taken which subsequently grew out Clostridium tetani. The wound was irrigated with 1,000 cc. of sterile saline solution and left wide open. It was dressed and splinted in such a fashion as to allow a vacoliter containing 300,000 units of penicillin and 20,000 units of tetanus antitoxin to irrigate the wound slowly. Three such vacoliters were used to irrigate the wound for the 16 hour period following the operation. After that, a 50% hydrogen peroxide solution was used to soak the finger 15 to 20 minutes every two hours. On the second hospital day because the signs had progressed, the patient was taken to the Operating Room where, under local anesthesia, an elective tracheotomy was performed. This tracheotomy was done before the need arose. This is important in overcoming the suffocating effects of laryngeal spasm and, almost as important, a tracheotomy permits aspiration of bronchial secretions which predispose to atelectasis and pneumonitis in a heavily sedated patient. These frequently are the cause of death in a case of tetanus.

Maintenance and management of the patient was accomplished by placing the patient in a quiet, single, darkened room with oxygen and a suction machine immediately available. She was sedated with sodium luminal by both the intravenous and intramuscular routes. Sedation was carried out under careful supervision. The patient received 100,000 units of penicillin every three hours for the first 48 hours and 300,000 units of penicillin in each vacoliter 10% glucose after that. Penicillin was given primarily to avoid respiratory complications. Indwelling Foley catheter was used to prevent urinary retention and to facilitate maintenance of a record of daily output. Usually, it was necessary to give 2,000 cc. of 5% dextrose in water and 1,000 cc. of saline daily during the acute illness. Periodic examinations of hematocrit, white blood

cell count, BUN, sodium chlorides and total protein were carried out. Also frequent urinalyses were carried out.

Hospital course: On the day of admission, the patient had a temperature of 100° (r) and trismus only. The following morning, she had spasm, rigidity of her neck and definite aching in her back. Her jaws became tight and she was almost unable to swallow. Her temperature rose steadily to 107° (r) on the third hospital day. Twitching movements of the extremities were noted, but no generalized convulsions. Her neck became completely stiff and her spine rigid. Her extremities were rigid, but could be bent on pressure. Abdominal muscles were spastic. Her temperature gradually fell from the fifth hospital day to the fifteenth hospital day. A definite pericardial friction rub was heard on the fifth hospital day and, at this time, an EKG was taken and found to be normal. The pericardial friction rub had disappeared two days later. Gradually, her spastic symptoms subsided. She was able to take a soft diet by her 12th hospital day. The latter portion of her hospital course was complicated by a urinary infection, right thigh abscess and thrombophlebitis of her right leg which were treated accordingly. This prolonged her hospitalization so that she wasn't allowed up until over a month after her admission. The tracheotomy tube was removed on the 13th hospital day and the wound allowed to granulate in. The soft tissues and fracture of the left middle finger were well on their way toward healing with a slight flexion deformity of the terminal phalanx when she was discharged on her 53rd hospital day.

PHYSICIANS SERVICE

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of indemnities, provided that inequities in the schedule would be adjusted as soon as the Service had established itself on a sound financial basis. These physicians have underwritten the success of the plan, even to the extent of agreeing to accept payments less than listed on the subscribers contract should the financial structure ever be endangered. In return the Physicians Service has a duty to amend its schedule of indemnities on a fair and equitable basis.

A committee of the Rhode Island Medical Society has made a detailed study of revisions of the indemnity benefits, and its findings have been given to the board of directors of Physicians Service. When the reserve fund required by the State Insurance Commissioner is determined, and when our study committees and actuaries have completed their research, we shall make adjustments accordingly for the benefit of the subscriber, and in fairness to the participating physicians. It will be our sincere hope that such revisions will result in a minimum premium increase, if any.

INFECTIOUS HEPATITIS

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ence of hepatic failure. Transfusions, plasma, and salt-free albumin are certainly indicated. Additional supplementary measures in the form of multivitamins and liver extract need little further comment. The liver has remarkable regenerative power, and if the individual's life can be maintained throughout the first several hours of the acute disease, progressive improvement may ensue.

It was felt that this case represented an example of severe liver failure, perhaps acute yellow atrophy, complicating pregnancy. A liver biopsy, unfortunately, could not be secured to substantiate the clinical impression. It was evident, nonetheless, that this patient's liver had simply failed and was unable to maintain any semblance of normal metabolic activity. Because extensive supportive therapy may maintain life during the acute phase of the disease, the importance of early recognition of the acute fulminating complication of infectious hepatitis cannot be stressed too highly.

BIBLIOGRAPHY

1 Stander: Textbook of Obstetrics, 9th Edition, Appleton-Century, 581, 1945.

2 Martin and Ferguson: Infectious hepatitis associated with pregnancy, New Eng. J. of Med., 237:114 (July 24) 1947.

3 Zondek and Bronberg: Infectious hepatitis in pregnancy, J. of Mt. Sinai Hosp., 14:222 (Sept.-Oct.) 1947.

4 Lichtman, S. S.: Origin and significance of tyrosinuria in disease of the liver, Arch. of Int. Med., 53:680, 1934.

5 Althausen, T. L.: Dextrose therapy in diseases of the liver, J.A.M.A., 100:1163 (April 15) 1933.

6 Soskin, G. and Hyman M.: Physiological basis of Intravenous dextrose therapy in diseases of the liver, Arch. of Int. Med., 64:1265, 1939.

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ANNUAL MEETING R. I. MEDICAL SOCIETY

The RHODE ISLAND MEDICAL JOURNAL

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MEDICAL EDUCATION

REFORMS in medical education date back almost a half century. The American Medical Association through its Council on Medical Education began a study of this problem in 1904, inaugurating the undertaking which was subsequently carried out by the Carnegie Foundation resulting in the investigation headed by Abraham Flexner that culminated in the now famous Flexner Report of 1910.

Standards rose, clinical facilities expanded, and teaching techniques became refined in the ensuing twenty years until a trend of events, beginning in 1932 and continuing to the present day, has not only slowed the progress of the previous two decades but seriously threatens its already impeded growth to survive at all.

Depression, war, and inflation have combined to affect the future quality of medical education as well as the continued operation of some medical schools due to the loss of income from endowments, a lowering of teaching standards necessitated by the war with its resultant deterioration in the quality of medical training, and the reduction in purchasing power caused by inflation.

This specter of insolvency encroaching upon the educational program of our medical schools has already been dimmed by the efforts of American Medicine together with the support of business, labor, and industry. The half million dollar contribution voted by the Board of Trustees of the AMA to be given to medical schools for their unrestricted use in the basic training of future doctors, in addition to the $285,000 already earmarked to advance medical education through the Council on Medical Education in 1951, will certainly elicit a generous response from all quarters of American life to protect and advance the interests of medical education and public health. Realization that federal subsidy is much more a burden than a blessing with its increased taxation and controls, has been the fundamental reason for American Medicine refraining from seeking federal aid for medical schools until every other source of financial aid has been exhausted.

For more than 14 years the Carnegie Institute has had an integrated program of professional education, a program which has stressed the factor of learning from professional experience. Applying the results of the study to the field of medical education, certain facts are worthy of note. Supplementing the preliminary report of the Committee on Medical School Grants and Finances appointed by the Surgeon General of the Public Health Service, Federal Security Agency, the National Advisory Health Council together with the American Medical Association's Committee on Survey of Medical Education and the Association of Medical Colleges, have covered the operations for the years 1947 and 1948 of 79 medical schools in which were enrolled over 23,000 students. The most significant fact developing from the study shows that expenditures doubled from 1940-41 to

1947-48 for basic undergraduate instruction. This was found to be due to increase in the cost of supplies and commodities, increase in salaries, and expansion of clinical facilities necessary for maintaining an ever enlarging scope of activities concerned with the broadening horizon of medical advance in many fields.

This loss of financial support was specifically shown in the decrease in income from tuition, actually 11% plus the loss of funds from endowment in these years which depreciated 10%.

The need of additional funds for the construction of new facilities as well as for current operating expenses if the present high standards of training with a margin for continued improvement are to be maintained, is altogether too obvious. This is further emphasized by the fact that 33 schools have had to curtail their programs, while some others have had to postpone improvements, because of lack of funds. Reduced to dollars, 34 schools need 4.5 millions for construction alone, while the total number of medical schools, both those operated publicly as well as privately, are in need of an estimated 350 to 400 millions of dollars for construction of facilities and current operation. It is significant that the greater part of this additional financial support would be devoted to an increase of 22% in freshman enrollment in the 79 medical schools all of which listed in the same order of frequency the (1) lack of space; (2) additional faculty; (3) new equipment.

The enthusiastic approval from the deans of medical schools throughout the country following the AMA's announcement of its appropriation of a half-million dollars to the nation's medical schools is perhaps epitomized in the comment of Dr. Donald Slaughter, Dean of South Dakota School of Medical Science, when he characterized it as "a most realistic precedent." Despite the belittling comments of "Trojan Horse" from a defeated congressman and "bitter last-ditch opposition" from a frustrated physician in the declining years of his professional life, labor has expressed its approval of this gesture to secure for the future the same and improved quality of medical education and care that has been the bequest of American medicine to the people of this country for the past half century.

The great importance of the nation's medical schools to every American citizen and the advancement of their standards is all too plain to doctors, but to project that importance to other segments of our citizenship is a responsibility we must not lose sight of in the confusion of everyday practice. The support of all allied organizations as well as individuals is essential for procuring the financial security of medical education in America. It is truly the most basic endeavor to protect our freedom against socialistic encroachment in medicine and other walks of life that Main street has known for the last century and a half.

A NEW MORPHINE SUBSTITUTE

Opium and its derivatives remain the "Gift of the Gods" in the relief of severe pain and discomfort and in the specific treatment of such conditions as acute pulmonary edema. Substitutes and synthetics are being added by intensive research to the original juice of the poppy and its alkaloids. One of the more recent is Methadone, which has been marketed under various trade names. We are now informed in an Army release that final validation of the value of Methadone has been made under the most rigid conditions and it can now be used as a substitute, interchangeable with morphine in an equal dosage, milligram for milligram. The racemic form is the one now on the market, though it is stated that the form known as Levo-Iso is the best to date. While the pain-killing power is as great as that of morphine, it appears to cause less tendency to addiction and far less nausea and vomiting. It does, however, have the same depressant effect upon respiration as does morphine. While generally administered subcutaneously, it may be given intravenously or by mouth.

The recent Army tests conducted under field conditions in the Korean battle area, indicated that it would be effective even when the temperature was 27° below zero. It has been noted, however, that men with severe wounds are not always in pain because emotion can block pain. Dr. Henry K. Beecher of the Massachusetts General Hospital, who conducted the field tests, felt that only one-fourth of seriously wounded men feel enough pain to need a pain relieving drug. From the viewpoint of world logistics, the new discovery makes this country independent of the foreign opium markets of Asia and the Near East.

Meperidine ("Demerol®") while very effective, has been somewhat disappointing in clinical practice, as regards the original claims of non-addiction, fewer side reactions and absence of respiratory depression. It is to be hoped that this newer synthetic will justify its promise in clinical practice.

PROVIDENCE PRESIDENTS

The Providence Medical Association, our biggest local Society, has recently had some awkward experiences with its list of officers which it has survived in a fine manner. For many years it has been a custom with this organization, and custom is strong in New England, to elect the vice-president; and after he has had one year of service, during which he has kept well in touch with the problems and workings of the organization, he has been elected president.

continued on next page

Following this excellent custom, Dr. Ubaldo Zambarano was elected president a year ago. There is no doubt in anybody's mind that had his health allowed him to serve, he would have made an outstanding president. Throughout years in an administrative position, he had demonstrated his great abilities. Unfortunately sickness overcame him just as he was about to begin his term, and Dr. Frank Dimmitt, who had not had the usual year of training, had to assume at a moment's notice this difficult job. We all know how ably Dr. Dimmitt met this emergency. It would have been asking too much of him to have gone on in the routine manner from vice-president to president. Once again the Association has had to elect a president who had not had the great advantage of a year's warning and observation.

The Association was fortunate in having the services of Dr. Louis I. Kramer available. He has become accustomed to administrative duties through service as Chief of the Medical Staff at the Miriam Hospital. He has spearheaded the public work in diabetes over a number of years, and we all recognize the high-class manner in which he has handled this big job. Besides being an administrator, Dr. Kramer is an internist of the highest standing. We know that with this background he will carry on the affairs of the Providence Medical Association in the manner to which we have become accustomed. Congratulations and best wishes to Dr. Kramer and to the Providence Medical Association.

CLEAN AIR

The Providence League of Women Voters had a symposium on air pollution a few days ago which was attended by the Mayor, Mr. Austin Daly, Air Pollution Engineer, and a number of other speakers. We believe this is a recurring episode with the League, and it should be so. Eternal effort is the only thing which will keep such improvements progressing.

Since Dr. B. Earl Clarke gave his presidential address before the Providence Medical Association some years ago and initiated this program against air pollution, there undoubtedly has been improvement in the city. Some of this improvement may have been due more to chance than good intentions. The New Haven Railroad has converted nearly all their locomotives to diesel engines. This is a great help.

Some of the biggest offenders have mended their ways. It is a pleasure to notice that the Providence County Court House no longer belches forth black smoke. Probably the biggest offender still is the Narragansett Electric Light Company. They have the biggest problem, and we suppose we will have to have patience while they gradually mend their ways. The chief engineer spoke at this meeting and gave some astonishing figures as to the amount of dry ash which they are already removing from their stacks and storing instead of throwing it into the air. We are not sure about the figures, but approximately they are collecting some 30 tons or so of this material every week. They report that they are going ahead as fast as they reasonably can in overcoming the smoke nuisance. We should commend them for this, but meanwhile keep a reproving watch over them. We believe that Mr. Daly is doing an excellent job, is already producing results, and we must continue to give him our active backing.

We believe that the State Medical Society's Committee on Air Pollution, headed by Dr. Edward S. Cameron, are doing monumental work. We cannot speak too highly of Dr. Cameron's intelligent and persevering efforts. From time to time we intend to report again on this matter.

ACADEMY OF GENERAL PRACTICE ANNOUNCES COURSES

The Rhode Island Chapter of the American Academy of General Practice announces its first postgraduate education course starting Wednesday, February 28, from 10 a. m. until noon, at St. Joseph's Hospital, Providence. The lectures will be continued at the same hours for eight successive Wednesdays. The course starting February 28 will be given by Dr. Robert E. Carroll, assistant in the department of medicine at Tufts College Medical School, and visiting cardiologist and physician at St. Joseph's Hospital. The course will be on "FUNDAMENTALS OF ELECTROCARDIOGRAPHY." Any physicians interested in this course should make application to Dr. Marden G. Platt, secretary of the Chapter. (Telephone: East Prov. 1-3836.)

UTILIZATION BY MAJOR CLASSES OF SERVICE — 1950

The R. I. Medical Society Physicians Service

Class of Service	IN HOSPITALS								OFFICE AND HOME					
	SURGEONS			ASSISTANTS		ANESTHETISTS		MEDICAL		SURGEONS		ANESTH'TS		TOTAL OF	ALL
General Surgery:	% – CS.	CS.	AMOUNT	CS.	AMOUNT	CS.	AMOUNT	CS.	AM'T	CS.	AM'T	CS.	AM'T	% – AM'T	CS.	AMOUNT
Infections	2.4	99	$1,777½	1	$ 15	23	$ 225	.....	$	182	$1,686	1	$ 10	1.3	306	$ 3,713½
Cysts	1.8	71	2,415	17	175	42	600	.....	.....	107	1,305	2	30	1.6	239	4,525
Tumors	2.7	111	2,910	7	75	45	500	.....	.....	100	1,290	1	10	1.7	264	4,785
Glands and Biopsies	.9	36	1,020	3	45	12	195	.....	.....	14	90	.....	.....	.5	65	1,350
Thyroid	.8	34	4,225	26	390	35	670	.....	.....	.....	.....	.....	.....	1.8	95	5,285
Breasts	1.8	71	4,960	39	485	78	1,035	.....	.....	9	285	1	10	2.4	198	6,775
Miscellaneous	1.9	78	4,535	17	225	51	810	.....	.....	28	513	.....	.....	2.1	174	6,083
Endoscopy	1.6	64	1,940	.....	.....	37	405	.....	.....	3	90	1	10	.8	105	2,445
Total General	13.9	564	23,782½	110	1,410	323	4,440	.....	.....	443	5,259	6	70	12.2	1,446	34,961½
Thoracic Surgery	.3	13	1,445	5	65	7	130	.....	.....	.....	.....	.....	.....	.6	25	1,640
Abdominal Surgery:																
Appendectomy	5.8	235	23,875	149	2,235	217	4,310	.....	.....	.....	.....	.....	.....	10.6	601	30,420
Cholecystectomy	2.4	97	12,285	75	1,125	85	1,640	.....	.....	.....	.....	.....	.....	5.2	257	15,050
Herniotomy	2.7	111	11,590	73	1,097½	102	2,025	.....	.....	.....	.....	.....	.....	5.1	286	14,712½
All Other	1.9	74	8,665	42	615	84	1,345	.....	.....	1	60	.....	.....	3.7	201	10,685
Total Abdominal	12.8	517	56,415	339	5,072½	488	9,320	.....	.....	1	60	.....	.....	24.6	1,345	70,867½
Proctology:	3.2	131	5,540	31	335	111	1,265	.....	.....	46	1,015	.....	.....	2.8	319	8,155
Urology	7.5	305	8,520	29	395	81	1,230	.....	.....	38	300	1	10	3.6	454	10,455
Obstetrics	16.2	655	33,800	15	225	47	740	.....	.....	1	25	1	10	12.1	719	34,800
Gynecology:																
Hysterectomy	4.9	200	30,020	133	1,990	191	3,520	.....	.....	.....	.....	.....	.....	12.3	524	35,530
All Others	6.3	253	15,220	75	1,080	200	2,980	.....	.....	51	530	3	30	6.9	582	19,840
Total Gynecology	11.2	453	45,240	208	3,070	391	6,500	.....	.....	51	530	3	30	19.2	1,106	55,370
Ophthalmology	1.7	67	5,375	22	275	25	370	.....	.....	59	950	1	10	2.4	174	6,980
Otology	.2	11	1,080	2	30	6	120	.....	.....	7	90	1	10	.5	27	1,330
Nose and Throat:																
T. and A.	27.2	1,102	29,128	.....	.....	858	6,872	.....	.....	241	6,165	174	1,394	15.1	2,375	43,559
All Other	1.3	53	3,800	2	30	22	375	.....	.....	33	584	2	20	1.7	112	4,809
Total Nose and Throat	28.5	1,155	32,928	2	30	880	7,247	.....	.....	274	6,749	176	1,414	16.8	2,487	48,368
Skull, Brain, Sp., Sym.	.9	36	4,020	11	160	34	535	.....	.....	.....	.....	.....	.....	1.6	81	4,715
Orthopedic	1.1	43	2,687½	12	140	34	485	.....	.....	.....	.....	.....	.....	1.2	89	3,312½
Amputations	.....	6	305	2	20	6	80	.....	.....	2	30	.....	.....	.1	16	435
Dislocations	.....	5	100	.....	.....	8	75	.....	.....	4	50	.....	.....	.1	17	225
Fractures and Casts	2.5	88	3,360	4	50	36	465	.....	.....	64	1,753	2	25	2.0	194	5,653
Nerve Blocks	.....	.....	.....	.....	.....	9	90	.....	.....	.....	.....	10	115	.1	19	205
Anesthesia — Teeth	.....	.....	.....	.....	.....	29	286	.....	.....	.....	.....	2	20	.1	31	306
Total Surgical	100.0	4,049	224,598	792	11,277½	2,515*	33,378*			990	16,811	203†	1,714†	100.0	8,549	287,778½
Medical in Hospital	.....	.....	.....	.....	.....	.....	.....	458	14,713	.....	.....	.....	.....	.....	458	14,713
Total Reported and Pd.	.....	4,049	224,598	792	11,277½	2,515*	33,378*	.....	.....	990	16,811	203*	1,714†	.....	9,007	302,491½
Total Unreported	.....	1,202	65,442	205	2,923	158	2,139	114	3,660	193	3,298	39	330	.....	1,911	77,792
Grand Total	.....	5,251	290,040	997	14,200½	2,673	35,517	572	18,373	1,183	20,109	242	2,044	.....	10,918	380,283½

* Includes Transfusions 92 555

† Includes Assistants 3 35

RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

Second Annual Meeting of the Corporation

At Providence, Rhode Island, January 17, 1951

THE SECOND ANNUAL meeting of the Corporation of the Rhode Island Medical Society Physicians Service was held at the Rhode Island Medical Society Library on Wednesday, January 17, 1951. The meeting was called to order by the President, Dr. Joseph C. O'Connell, at 8:30 p. m.

The following members of the Corporation were in attendance:

Rocco Abbate, M.D.
Peter C. Erinakes, M.D.
Donald B. Fletcher, M.D.
Frank Logler, M.D.
Earl J. Mara, M.D.
Charles L. Farrell, M.D.
Henry Hanley, M.D.
Samuel Nathans, M.D.
Victor H. Monti, M.D.
John A. Mellone, M.D.
Louis I. Kramer, M.D.
Herman A. Lawson, M.D.
Morgan Cutts, M.D.
Earl F. Kelly, M.D.
Robert Baldridge, M.D.
J. Murray Beardsley, M.D.
Frederic J. Burns, M.D.
Francis H. Chafee, M.D.
Peter Pineo Chase, M.D.
Frank B. Cutts, M.D.
William P. Davis, M.D.
Donald DeNyse, M.D.
John Dillon, M.D.
Michael DiMaio, M.D.
William J. H. Fischer, M.D.
Peter Harrington, M.D.
William Horan, M.D.
Russell Hunt, M.D.
Robert Murphy, M.D.
John C. Myrick, M.D.
Joseph C. O'Connell, M.D.
Edwin B. O'Reilly, M.D.
Alfred L. Potter, M.D.
Louis Sage, M.D.
Daniel V. Troppoli, M.D.
George Waterman, M.D.
Orland F. Smith, M.D.
Louis E. Burns, M.D.
Albert H. Jackvony, M.D.
Felix A. Mirando
Emil Fachon
Walter F. Farrell
George R. Ramsbottom

Also present were William E. McCabe, legal counsel, Stanley H. Saunders, executive director, Edgar Clapp, assistant executive director, and John E. Farrell, executive secretary.

Address of President

Dr. Joseph C. O'Connell addressed the Corporation on the first year's progress of Physicians Service, and on the outlook for 1951. His remarks are made part of the official minutes of this meeting.

Annual Report of Secretary

Dr. Morgan Cutts, secretary of the Corporation, read his annual report, copy of which is made part of the official minutes of this meeting.

The annual report of the secretary was received and placed on file.

Annual Report of the Treasurer

In the absence of the Treasurer, his financial report for the year 1951, as audited by certified public accountants, was presented by Dr. Morgan Cutts.

The report was received and placed on file as an official part of the minutes of this meeting.

Nominations for Board of Directors

The Secretary reported that the House of Delegates of the Rhode Island Medical Society submits as its nominees to serve three year terms as members of the board of directors of Physicians Service the following:

ROCCO ABBATE, M.D.
FRANK B. CUTTS, M.D.
EARL J. MARA, M.D.
ORLAND F. SMITH, M.D.

It was moved that these nominees be elected by the Corporation to serve three year terms, starting this date, as members of the board of directors of the Rhode Island Medical Society Physicians Service. The motion was seconded and adopted.

Adjournment: The business of the Corporation completed, Dr. O'Connell declared the meeting adjourned, and he called for a meeting of the board of directors to be held immediately.

Respectfully submitted,
MORGAN CUTTS, M.D., *Secretary*

Report of the Secretary to the Corporation, January 17, 1951

During 1950 the Board of Directors of the Rhode Island Medical Society Physicians Service held six meetings, in January, March, July, October, November, and December.

The board elected as officers of the Corporation the following:

Joseph C. O'Connell, M.D., President
Rocco Abbate, M.D., Vice President
Morgan Cutts, M.D., Secretary
Charles J. Ashworth, M.D., Treasurer

Elected as representatives of the public on the board were the following:

Thomas A. Dignan,
President, Narragansett Electric Company
John Shepard, III, of the Shepard Company
Walter F. Farrell,
President, Union Trust Company Now—Providence Union National Bank and Trust Company
George R. Ramsbottom,
President, Seekonk Lace Company

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PHYSICIANS SERVICE

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Elected as additional public representatives were the two following nominees of the Hospital Service Corporation of Rhode Island:

Felix A. Mirando,
Secretary-Treasurer, Imperial Knife Co.

Emil E. Fachon,
President, Bulova Watch Company

* * *

The Board of Directors approved of the recommendation of the Corporation that the By-laws be amended, and the following amendment was adopted:

Article I., Section 1,(d) was amended to read: ", and (d) such other persons, *non-physicians*, as may be elected to membership in the Corporation by its Board of Directors, ..."

(underscored is amendment)

The Board of Directors organized sub-committees on professional relations, executive, finance, and joint operations, all of which have worked effectively during the year. The Board has carried out the many details of organization and administration during the past year, including such matters as subscriber relations, report forms, direct enrollment, financial problems, payment of claims, recommendations from participating physicians, legal opinions, executive actions, and study of the schedule of indemnities and of the subscriber contract. These many matters are reported in detail in the minutes of the meetings of the Board which are available for inspection by members of the Corporation.

Your President will report to you of the first year of Physicians Service and from the reports that have been brought to your attention during the year I am sure you are familiar with the major work that has been carried forward successfully. As your Secretary I express my personal appreciation for the excellent cooperation and attendance at all meetings of the board of directors, and the various committee meetings during the year. The work of the Joint Operations Committee, and the Claims Committee, deserve particular commendation, for the members of these committees have met very frequently to settle many vexing administrative problems as our Service progressed through the year.

Respectfully submitted,
MORGAN CUTTS, M.D., *Secretary*

Ward, Fisher & Company
Certified Public Accountants

January 16, 1951

To the Board of Directors of the Rhode Island Medical Society Physicians Service:

We have made an examination of the financial records of the Rhode Island Medical Society Physicians Service for the year ended December 31, 1950.

The results of our examination are presented in the following exhibits forming a part of this report:

Exhibit A — Balance Sheet, December 31, 1950

Exhibit B — Statement of Income, Year ended December 31, 1950.

The following comments pertaining to certain items in the attached statements are furnished for your further information.

CASH IN BANKS: Cash on deposit in banks was verified by correspondence with the depositaries.

ACCOUNTS RECEIVABLE: This item represents subscriptions due and earned.

ACCOUNTS PAYABLE: At December 31, 1950 the Physicians Service was indebted to Hospital Service Corporation of Rhode Island in amount of $3,455.45 for operating expenses for the month of December. Under the joint operations agreement, operating expenses for both Hospital Service and Physicians Service are paid by the Hospital Service Corporation and the allocation of such expenses to Physicians Service is made monthly on a basis of percentage of number of contracts in force for each plan at the end of each month. All such calculations have been verified by us.

Accounts payable of $42,261.50 for surgical and medical services rendered prior to January 1, 1951 were verified by reference to vouchers paid in January 1951.

ACCRUED SURGICAL AND MEDICAL EXPENSE: This item represents estimates of the liability for patients admitted prior to January 1,

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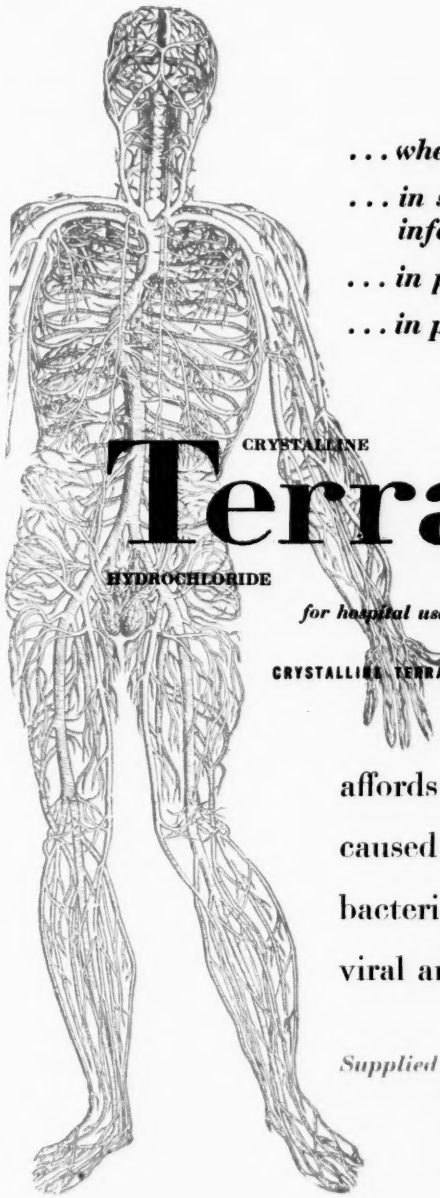

. . . when oral therapy is not feasible

. . . in severe, fulminating or necrotizing infections

. . . in pre- and postoperative prophylaxis

. . . in peritonitis

CRYSTALLINE

Terramycin

HYDROCHLORIDE

for hospital use only

INTRAVENOUS

CRYSTALLINE TERRAMYCIN HYDROCHLORIDE FOR INTRAVENOUS INJECTION

affords *rapid* control of infections caused by organisms in the bacterial, rickettsial and certain viral and protozoan groups

Supplied: 10 cc. vials containing 250 mg. of Crystalline Terramycin Hydrochloride with sodium glycinate as a buffer.

20 cc. vials containing 500 mg. of Crystalline Terramycin Hydrochloride with sodium glycinate as a buffer.

Antibiotic Division **Pfizer** CHAS. PFIZER & CO., INC., *Brooklyn 6, New York*

PHYSICIANS SERVICE

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1951, for whom service reports had not been received. Computation of the accrual was reviewed by us.

UNEARNED SUBSCRIPTIONS: Calculations of unearned subscriptions allocable to future periods were verified.

RESERVE FOR SURGICAL AND MEDICAL EXPENSE: Details of the items affecting this account for the period under examination are reflected in Exhibit B.

GENERAL: Exhibit B reflects the income for the period under examination, its allocation, and the various operating expenses.

Our examination was made in accordance with generally accepted auditing standards applicable in the circumstances and included all procedures which we considered necessary.

Substantial tests were made in verification of receipts and disbursements.

In our opinion, the accompanying balance sheet and related statement of income present fairly the position of the Rhode Island Medical Society Physicians Service at December 31, 1950, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles consistently applied.

Respectfully submitted,

WARD, FISHER & COMPANY,

Certified Public Accountants

Exhibit A

RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

Balance Sheet

December 31, 1950

ASSETS

CURRENT ASSETS:		
Cash in banks		$288,543.57
Accounts receivable		1,131.54
Total assets		$289,675.11

LIABILITIES AND RESERVES

CURRENT LIABILITIES:		
Accounts payable:		
Hospital Service Corporation of R. I.	$ 3,455.45	
Surgical and medical services	42,261.50	
Accrued surgical and medical expense	77,792.00	$123,508.95
DEFERRED INCOME:		
Unearned subscriptions		6,989.00

RESERVES:		
Reserve for surgical and medical expense — exhibit B		159,177.16
Total liabilities and reserves		$289,675.11

Exhibit B

Statement of Income

Year ended December 31, 1950

INCOME:		
Earned subscriptions		$583,192.88
OPERATING EXPENSES:		
Allocation of expenses by Hospital Service Corporation, under operating agreement	$ 35,397.07	
Other expenses paid direct by Physicians Service:		
Legal, auditing and Executive Secretary expense	5,169.70	
Printing and stationery	432.07	
Insurance and bonds	393.80	
Directors' meetings	166.80	
Postage	25.00	
Total operating expenses	$ 41,584.44	
ORGANIZATION EXPENSES	2,147.78	
Total operating and organization expenses		43,732.22
INCOME ALLOCATED TO RESERVE FOR SURGICAL AND MEDICAL EXPENSES		$539,460.66
SURGICAL AND MEDICAL EXPENSE:		
Participating physicians	$314,071.50	
Non-participating physicians	66,212.00	380,283.50
RESERVE FOR SURGICAL — MEDICAL EXPENSE, DECEMBER 31, 1950		$159,177.16

DISTRICT MEDICAL SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

The 104th annual meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, January 8, 1951. The meeting was called to order by President Frank W. Dimmitt, M.D. at 8:40 p. m.

The reading of the minutes of the previous meeting of the Association was omitted by the consent of the membership present.

Dr. Daniel V. Troppoli presented the annual report of the Secretary of the Association for the year 1950. It was motioned, seconded, and adopted that this report be received and placed on file. The report of the Treasurer for 1950 was read by the Secretary in view of the absence of J. Murray Beardsley, M.D., Treasurer. It was moved, seconded, and adopted that this report be received and placed on file.

LOUIS I. KRAMER, M.D.
President, 1951
THE PROVIDENCE MEDICAL ASSOCIATION

The Secretary reported for the Executive Committee as follows:

The Executive Committee has held two meetings since the November meeting of the Association. The following were among actions taken by the Committee:

1. The financial report of the annual dinner and golf tournament was received and placed on file.
2. A slate of officers and delegates was proposed to the Association.
3. The Committee concurred with the opinion expressed by the Council of the Rhode Island Medical Society relative to the fluoridation of the water supply.
4. The annual report of the Treasurer regarding the funds of the Association and of the Medical Bureau was received and filed for presentation to the Association.
5. The Advisory Committee to the Medical Bureau was authorized to increase its monthly charge to subscribers one dollar to meet operating costs.
6. The Insurance Committee was authorized to continue its study of a group life insurance policy for the membership and to submit its findings to the executive committee.

The President called upon Dr. Herman P. Grossman to present the Association's tribute to the late Dr. Harry C. Messinger, a former president of the Association. Dr. Grossman read the obituary prepared by himself and Dr. George W. Van Benschoten.

The Presidential Address was then delivered by Dr. Frank W. Dimmitt in which he viewed in particular the development of the Medical Bureau of the Association, which within a year has become the second largest medical society-operated telephone exchange in the East.

The Secretary moved that the slate of officers be submitted to the membership by the Executive Committee to serve the Association in 1951. The slate was as follows:

President	Louis I. Kramer, M.D.
Vice President	Frederic J. Burns, M.D.
Secretary	Michael DiMaio, M.D.
Treasurer	Robert G. Murphy, M.D.

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PROVIDENCE MEDICAL ASSOCIATION

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Trustee (1 year).....Herbert E. Harris, M.D.
Councillor (2 years).....Frank W. Dimmitt, M.D.

Delegates:

Charles J. Ashworth, M.D.	Herman P. Grossman, M.D.
Robert Baldridge, M.D.	Peter Harrington,M.D.
J. Murray Beardsley, M.D.	William Horan, M.D.
Frederic J. Burns, M.D.	Russell Hunt, M.D.
Francis H. Chafee, M.D.	Louis I. Kramer, M.D.
Peter Pineo Chase, M.D.	Edward McLaughlin, M.D.
Frank B. Cutts, M.D.	Robert Murphy, M.D.
Harry E. Darrah, M.D.	John C. Myrick, M.D.
William P. Davis, M.D.	Joseph C. O'Connell, M.D.
Donald DeNyse M.D.	Edwin B. O'Reilly, M.D.
John Dillon, M.D.	Alfred L. Potter, M.D.
Michael DiMaio, M.D.	Louis Sage, M.D.
William J. H. Fischer, M.D.	Daniel V. Troppoli, M.D.
David Freedman, M.D.	George Waterman, M.D.

The Secretary moved that the slate of officers and delegates as submitted by the Executive Committee be adopted by the Association. The motion was seconded and unanimously carried.

Dr. Dimmitt called upon Dr. Paul C. Cook and Dr. George W. Waterman to escort the new President, Dr. Louis I. Kramer, to the platform.

Dr. Kramer addressed the Association briefly, urging the members to offer suggestions and constructive criticisms to aid the program of the Association in the coming year. At the conclusion of his address, he presented an engraved gavel to Dr. Dimmitt as a token of appreciation from the Association for his leadership during the last year.

The President introduced the new vice-president, Dr. Frederic J. Burns; the new Secretary, Dr. Michael DiMaio; and the new Treasurer, Dr. Robert G. Murphy, each of whom rose to receive the applause of the membership.

The President reported that the various committees of the Association had submitted reports which will be printed in the RHODE ISLAND MEDICAL JOURNAL. He invited any committee chairman desiring to bring any matter to the attention of the membership at this time to do so.

Dr. J. Merrill Gibson, chairman of the Association's Disaster Committee, reported briefly on the work to be carried on by his committee, and he urged the support of the entire membership in the work.

The Secretary reported that the committee consisting of Dr. Walter Gordon and Dr. James F. Boyd has submitted the Association's memorial tribute to the late Dr. George F. White of Auburn. The tribute will be placed in the records, and a copy sent to his family.

The Secretary reported that the Executive Committee recommends for election to active membership the following physicians:

Leonard B. Bellin, M.D.
John F. Gilman, M.D.
Ernest J. Smith, M.D.

It was moved, seconded, and adopted that these physicians be unanimously elected to active membership.

In the absence of the Treasurer, the Secretary reported that the executive committee of the Association has reviewed a proposed budget, closely paralleling that for the operation of the Association during the past year, and has approved this budget calling for expeditures of $7,495, and it recommends its adoption by the Association.

The Executive Committee also recommends that the dues for active members in 1951 be $15, and for associate members $5; provided, however, that members serving with the armed forces shall be exempt from the payment of such dues. He moved the adoption of these recommendations. The motion was seconded and unanimously adopted.

Dr. Frank W. Dimmitt presented as the guest speaker of the evening, Dr. Priscilla White of Boston, Massachusetts, physician, New England Deaconess Hospital; associate physician, Boston Lying-In Hospital; instructor of pediatrics, Tufts Medical School; instructor, Harvard Medical College; who spoke on "Management of Diabetes in Pregnancy."

In the management of the pregnant diabetic, Dr. White states there must be cooperation between the internist, obstetrician, and the pediatrician also, after delivery. The patient is examined weekly by the internist and obstetrician, and after delivery, the pediatrician joins the group. The program is set to protect the vulnerable eyes and kidneys of pregnant women.

At the onset, a diet suitable to both the diabetic and pregnant state is given. At first C-180, P-90, F-90, and toward the end C-250, P-150, F-100. Until recently, multiple injections of insulin in twenty-four hours were used. Now N. P. H. insulin is used successfully in controlling patients with a single dose in 2/3 of the cases.

Diabetic pregnant women have a low renal threshold for glucose and are very unstable, usually in and out of acidosis, and in and out of insulin reactions constantly.

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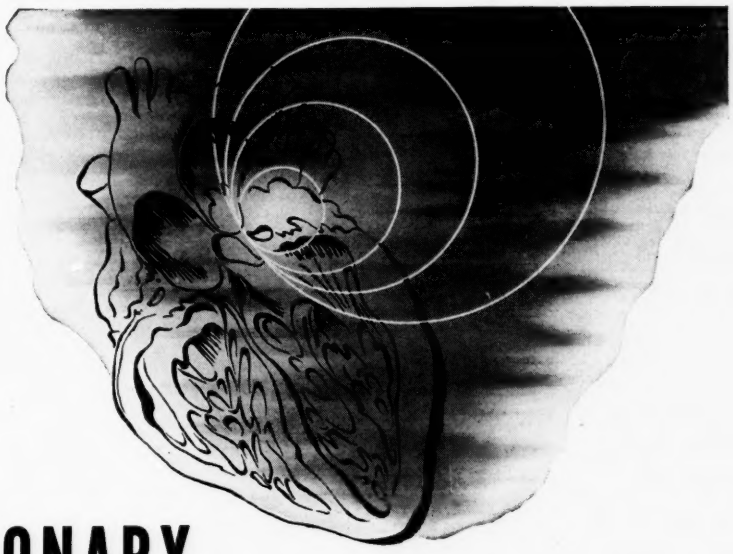

CORONARY DILATION...*the basic approach*

To improve and strengthen the action of the failing heart through dilating the coronary arteries and to reduce the energy requirements of the heart by mild sedation, are widely desired treatment aims. A great host of physicians recognize theobromine and the sedative, phenobarbital, as admirably suited to these requirements.

Abundant evidence exists that theobromine dilates the coronary arteries. Theobromine also provides safe myocardial stimulation and diuresis. TCS offers the excellent theobromine salicylate, highly efficient because of its extremely high intestinal solubility and absorbability, and uniformly well tolerated because of calcium salicylate, which reduces the gastric solubility of theobromine salicylate.

TCS tablets

DOSAGE: One to two tablets 3 to 4 times daily. Reduce with improvement.

SUPPLY: In bottles of 50 and 250 tablets. Each TCS Tablet supplies 6 gr. theobromine salicylate, 1 gr. calcium salicylate and ¼ gr. phenobarbital.

POYTHRESS

WILLIAM P. POYTHRESS & CO., INC., RICHMOND, VA.

PROVIDENCE MEDICAL ASSOCIATION

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In the second trimester, ketosis is harmful to the infant. The retinae are examined weekly, and rutin is given if hemorrhages are seen. Also weekly N. P. N., albumens, and sediments are done. Minimal findings receive the maximum care.

For edema and hydramnia, hormonal therapy is used. This is substitutional and not stimulative. The patient is also placed on a salt free diet, and mercurials are also used for the edema.

Patients with vascular disease, i. e., calcification of arteries in pelvis and legs, are most apt to have still births. 2/3 of the still births occur between the 34th and 40th week.

In general, the patients are classified according to the severity of the disease, eye changes and calcifications making them more severe. The more severe the disease, the earlier they are delivered by cesarean section. Any signs of eclampsia, sudden loss of fetal activity, sudden drop in chorionic gonadotropin, are all indications for emergency delivery.

Diabetic women have a tendency toward anemia and a wastage of Vitamin B, therefore, vitamins and iron in excess are given.

Hormonal therapy has lowered the fetal mortality and eclampsia incidence. This therapy is given when the patient is first pregnant. The amount varies with the clinical classification of the patient, which is based on the severity of the diabetes, age of onset, and presence or absence of retinal lesions.

Delivery is done under spinal anesthesia; the last dose of insulin is given twenty-four hours prior to delivery. The next dose is given on return from surgery.

The care of the infant is directed against respiratory difficulty which is their chief problem, e. g., signs of respiratory distress, cyanosis, apnoea, sweating. Death may occur thirty-six hours after delivery. This is due to infants sucking amniotic fluid in their air passages. Therefore, the head is extracted carefully and the mouth is kept closed. The infants are drained manually for a longer time. A number 10 catheter is passed into the upper air passages and suctioned. Then it is passed into the stomach, and the stomach is aspirated. The infant is then placed in an incubator with oxygen for five days. Recently, the addition of a nebulizer to the incubator has helped. Occasionally, some infants have insulin reactions, they are jittery, fiery red, and their blood glucose is down to 10mg. due to transference of maternal insulin. These are treated with glucose.

The meeting was adjourned at 10:30 p. m.

Collation was served.

Attendance: 80.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D., *Secretary*

NEWPORT COUNTY MEDICAL SOCIETY

A meeting was called to order by President Henry Brownell at 9:00 p. m. on November 28, 1950.

The suggested change in constitution (section 3 pertaining to eligibility for membership) was approved.

The application of Dr. Ernest Landsteiner was approved for consideration and forwarded to the censors.

The inadequacies of collecting for relief patients were discussed and the delegates were requested to bring the matter to the attention of the Rhode Island Medical Society.

The location of dinner for the January meeting was left to the discretion of the President and Secretary.

The following change in By-Laws was approved for posting:

Chapter V, Section 2 of By-Laws shall be changed to include "any member of the Newport County Medical Society, on reaching the age of 60 may be excused from payment of dues at his own request."

Meeting adjourned at 10:30 p. m.

Collation.

Respectfully submitted,

M. OSMOND GRIMES, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The December meeting and Christmas party of the Pawtucket Medical Association was held at the Pawtucket Golf Club on December 20.

President James P. Healey appointed a committee for the nomination of officers for the coming year, naming Drs. Edward Trainor, Howard Umstead, and Henry Turner.

Since there was no other business to come before the meeting, a dinner was served and the party conducted by Dr. Earl F. Kelly as master of ceremonies. Gifts and stories were exchanged and several door prizes were presented by the committee which consisted of Drs. Boucher and Czekanski.

Thirty-one members and one guest were present.

Respectfully submitted,

HRAD ZOLMIAN, M.D., *Secretary*

MONDAY, March 5 . . .

Meeting of Providence Medical Association

"Surgery of the Mitral Stenosis"

DRS. DWIGHT HARKEN AND LAWRENCE ELLIS

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY
Report of Meeting Held January 17, 1951

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, January 17, 1951. In the absence of the president, vice-president, and president elect, the meeting was called to order by the past president, Dr. Joseph C. O'Connell, at 8:05 p.m. The following delegates were in attendance during the meeting:

Kent County
Rocco Abbate, M.D.
Peter C. Erinakes, M.D.

Newport County
Donald B. Fletcher, M.D.
Frank Logler, M.D.

Pawtucket Medical
Henry Hanley, M.D.
Earl J. Mara, M.D.
Charles L. Farrell, M.D.

Washington County
Samuel Nathans, M.D.

Woonsocket County
Victor H. Monti, M.D.

Bristol County
John A. Mellone, M.D.

Officers
Charles J. Ashworth, M.D.
Herman A. Lawson, M.D.
Morgan Cutts, M.D.
Earl F. Kelly, M.D.

Providence Medical Association
Charles J. Ashworth, M.D.
Robert Baldridge, M.D.
J. Murray Beardsley, M.D.
Frederic J. Burns, M.D.
Francis H. Chafee, M.D.
Peter Pineo Chase, M.D.
Frank B. Cutts, M.D.
William P. Davis, M.D.
Donald DeNyse, M.D.
John Dillon, M.D.
Michael DiMaio, M.D.
William J. H. Fischer, M.D.
Peter Harrington, M.D.
William Horan, M.D.
Russell Hunt, M.D.
Louis I. Kramer, M.D.
Robert Murphy, M.D.
John C. Myrick, M.D.
Joseph C. O'Connell, M.D.
Edwin B. O'Reilly, M.D.
Alfred L. Potter, M.D.
Louis Sage, M.D.
Daniel V. Troppoli, M.D.
George Waterman, M.D.

Dr. O'Connell called for nominations for the House of Delegates of four Fellows to serve three-year terms as members of the Board of Directors of the Rhode Island Medical Society's Physicians Service.

The name of Orland Smith, M.D. was placed in nomination. It was moved that Drs. Orland Smith, Rocco Abbate, Frank Cutts, and Earl J. Mara, all of whom are completing a year of service as directors of Physicians Service, be renominated to serve for three-year terms. The motion was seconded and adopted.

REPORT OF THE SECRETARY

Dr. Morgan Cutts, Secretary, reported as follows:

Since the previous meeting of the House of Delegates the Council has held two meetings at which the following actions were taken:

1. *Practical Nurse Training.* The action of the state committee on Nursing Education in seeking to obtain the establishment of a program for organized practical nurse training in Rhode Island was endorsed, and the State was urged to make funds available for such a program. Dr. Earl F. Kelly of Pawtucket was named by the Council to be the Society's representative to serve on the Practical Nurse Committee established by the State Department of Education.

2. *State Essay Contest.* The Kent County Medical Society was commended for its leadership in sponsoring an essay contest on the subject "Why the Private Practice of Medicine Furnishes this Country with the Finest Medical Care", and the President of the Rhode Island Medical Society was authorized to initiate a statewide program offering for the Society $100 in prizes.

3. *Midcentury White House Conference.* The report of the Rhode Island Committee on the Midcentury White House Conference on Children and Youth was referred to the Society's committee on Postgraduate Education for the study and report to the House of Delegates, particularly as regards reported unmet health needs.

4. *Congress on Industrial Health.* The chairman of the Society's committee on Industrial Health was authorized to represent the Society at the Congress on Industrial Health of the AMA to be held in Atlanta, Georgia on February 26 and 27, and the treasurer was authorized to refund the chairman his travel and lodging expenses in connection with attendance at this meeting.

5. *Agency Account for Society's Funds.* The status of the various invested funds of the Society was reviewed by the Council and the Treasurer was authorized to sign an agreement with the Industrial Trust Company for the establishment of an agency account.

6. *AMA Dues.* The Secretary was instructed to notify all members who had not paid their 1950 AMA dues of the importance of clearing the indebtedness before the end of the calendar year 1950. The Treasurer was authorized to send out bills for 1951 AMA dues at his convenience.

7. *Fluoridation of Water Supplies.* A request from the Rhode Island State Dental Society that

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HOUSE OF DELEGATES

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the Rhode Island Medical Society consider the problem of fluoridation of the water supplies was given careful study. The Council decided that in view of the present status of scientific knowledge regarding the fluoridation of water supplies the Society would not be prepared to approve the program at this time, but it would urge the continued careful study of tests being made elsewhere until more conclusive evidence is available.

8. *Advisory Committee to Selective Service.* The professional advisory committee to Selective Service was authorized to utilize the services of the executive secretary and the executive office to aid it until such time as the national organization shall provide services otherwise.

9. *Study of Hospitalization Costs.* The Council authorized the President to invite a group of representative citizens to meet with physicians and hospital representatives to study the entire problem of the costs of hospitalization in Rhode Island.

10. *Providence Medical Bureau.* The Council voted to recommend to the Providence Medical Association that it make a donation of up to $50 monthly, starting January 1, 1951, towards the costs incidental to the operation of its Medical Bureau in the Library building.

11. *Library Committee.* The request of the Library Committee for approval of the employment of a part-time employee for the Librarian, in order that the cataloguing of Library data may be completed, was approved.

12. *Mental Health Committee.* The President was authorized to appoint a committee on mental health.

13. *Blood Bank Committee.* The establishment of a Blood Bank Committee of the Society was approved, and the President was authorized to name the members of the committee.

14. *Library Repairs.* Certain necessary repairs to the Library building were approved and the Trustees were authorized to have the work done upon advice of the Society's architects.

15. *AMA Motion Picture.* The Secretary was authorized to secure from the American Medical Association a copy of its film "Here's Health the American Way" for showing to the membership, and distribution to the district societies upon request.

Recommendations from the Council

The secretary reported that the Council recommended:

1. That the dates for the 141st Annual meeting be set for Wednesday, May 14, and Thursday, May 15, 1952, and that the meeting be held in Providence.

It was moved to adopt this recommendation of the Council. The motion was seconded and passed.

* * *

2. That the House give consideration as to where it would like to hold the 1951 interim session, and at what time of year it would like it held.

Dr. Samuel Nathans extended an invitation from the Washington County Medical Society that the Rhode Island Medical Society hold the interim session at the Dunes Club at Narragansett Pier, Rhode Island, on September 19, 1951.

It was moved to accept the invitation extended by the Washington County Medical Society. The motion was seconded and adopted.

* * *

3. That Dr. G. Raymond Fox of Pawtucket and Dr. Frederic J. Burns of Providence be nominated as the Society's representatives on the Board of Directors of the Rhode Island Hospital Service Corporation for the year 1951.

It was moved, seconded, and adopted that this recommendation be approved.

Report of the Committee on Social Welfare

Dr. Peter F. Harrington, chairman of the committee on Social Welfare, read the report of his Committee which is made a part of the official minutes of this meeting. Dr. Harrington discussed this report briefly.

* * *

Dr. O'Connell moved that the House of Delegates recess at this time in order to meet as the Corporation of the Rhode Island Medical Society's Physicians Service. The motion was seconded and adopted.

* * *

The House of Delegates reconvened at 9:30 p. m., President-Elect, Dr. Herman A. Lawson, presiding.

The members of the House of Delegates discussed the report of the Committee on Social Welfare.

Dr. Lawson asked for the decision of the House on the recommendations advanced, stating the first to be the recommendation that, "The Medical Society handle emergency calls on a different basis and assign various doctors in the community to certain specific nights or days in which they would have full responsibility for immediate response to the calls of the public relief recipients."

It was moved that the House, being conscious of the urgent need for a better solution of the problem of medical care for welfare patients, urges prompt action by the district medical societies.

The motion was seconded and adopted.

Dr. Morgan Cutts suggested that the district societies endeavor to work out the problem with the State Society's Committee on Social Welfare.

* * *

Dr. Lawson asked for action on the second recommendation "that direct payment be made to the physician by the Department of Social Welfare for the services rendered."

It was moved to accept this recommendation. The motion was seconded and adopted.

Report of the Cash Sickness Committee

Dr. Charles J. Ashworth, president of the Society, arrived at the meeting after attending the annual session of the Rhode Island Dental Society, and he took over the chair as presiding officer. He called for the report of the Advisory Committee on the Cash Sickness Compensation Program.

Dr. Herman C. Pitts read his report which had been submitted in mimeographed form to the members of the House prior to the meeting.

It was briefly discussed, and it was moved that it be adopted and placed on record. The motion was seconded and carried.

Dr. Ashworth stated that unless there was objection from the House, the report of the Cash Sickness Committee would be released to the press. There was no objection expressed to such action.

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HOUSE OF DELEGATES

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Committee on Public Relations

Dr. Charles L. Farrell, chairman of the Committee on Public Relations, reported that the motion picture film "To Your Health" had been shown in seven theatres before an estimated audience of 28,244 persons.

He also reviewed the national health legislation that has already been introduced in the 82nd Congress.

He briefly discussed the Public Relations Conference of the American Medical Association held in Cleveland in December.

He concluded his remarks by pointing out the obligations of the medical profession to require new members of district societies to handle emergency calls night and day, and recommended that the societies be urged to take such action.

It was moved to accept the report of the chairman of the Committee on Public Relations. The motion was seconded and carried.

Fiske Fund

Dr. Ashworth reported briefly regarding the Caleb Fiske Fund, stating that an agency account had been established with the Industrial Trust Company for the better investment of funds, and reported that the program would be administered by the trustees of the Fiske Fund in accordance with the will as in the past.

Registration of Doctors

Dr. Ashworth called attention to the newspaper announcement that some physicians had not registered under the selective service act due to a misunderstanding arising from the local selective service headquarters relative to what doctors were subject to registration. He urged the delegates to convey the message to district societies that any men in doubt regarding their status should communicate directly with state selective service headquarters.

The meeting adjourned at 10:12 p. m.

Respectfully submitted,

MORGAN CUTTS, M.D., *Secretary*

REPORT OF CASH SICKNESS PROGRAM ADVISORY COMMITTEE TO THE HOUSE OF DELEGATES, JANUARY 17, 1951

The Society's committee advisory to the State Division of Employment Security relative to the cash sickness compensation program reports excellent cooperation on the part of the administering agency in working out improvements to the medical phases of the program.

We have met on several occasions during the year, and we have carefully reviewed the program, always seeking to make it more efficient and beneficial to the people of the State for whom it has been established. The certifying form has been modified and made simpler to effect prompt reporting. The impartial examiner system has been operated to the better advantage of the patient-participant in the program.

Recently the cash sickness program has been studied by Dr. Nathan Sinai of the School of Public Health of the University of Michigan. It has also been subject to review by the local administrators who have made definite recommendations for the improvement of the program.

It is significant that only in very recent years has the medical profession been rightfully considered in the administration of this program, the success of which depends upon the physicians of Rhode Island. It is also significant that some of the observations, medical and otherwise, made by leaders of both the Rhode Island Medical Society and the Providence Medical Association as far back as 1942, pointed clearly to the problems that now beset the program.

Pregnancy and Maternity Benefits

Foremost among the problems endangering the financial structure of the cash sickness fund is that of the payment of pregnancy and maternity benefits. Yet when the law was originally written there was no provision for the payment of other than the complications of pregnancy. The medical profession was not consulted when by administrative regulation all pregnancies were made compensable, with the ultimate result that one third of the annual fund is now depleted each year to pay for maternity benefits.

When recommendations were made to the General Assembly to amend the cash sickness law in 1945, the House of Delegates of the Rhode Island Medical Society at that time stated: "In administering the program the Board has recognized the condition of pregnancy as a disability compensable under its interpretation of the sickness compensation law. In the initial report the certifying physician is required to attest to pregnancy as a specific disability, whereas he knows that in itself pregnancy is not a sickness or disability and does not necessarily justify absence of the worker from employ-

ment throughout the period. It is the conditions arising from pregnancy that justifiably constitute sickness or disability claims which the worker rightfully may make under the law."

And the Society at that time recommended that: "The law as written be correctly interpreted to understand that sickness or disability arising from, or complications due to pregnancy, be compensable in accordance with the provisions of the sickness compensation act, and that all such benefits paid shall be independent of any maternity benefits that may hereafter be provided for under the program by act of the General Assembly."

Those statements were widely publicized. Yet a year later the General Assembly tried to cope with the problem by merely cutting down the number of benefit weeks for which a pregnant woman might collect compensation. At that time the law was amended to provide that: "No individual shall be deemed eligible for benefits for a period in excess of 15 weeks for unemployment due to sickness resulting from pregnancy, whether such sickness be prenatal, postnatal, or a combination of both; *provided however,* that the aforesaid limitations shall not apply to unusual complications arising as a result of childbirth."

Thus, in effect, the General Assembly strengthened the previous administrative legislation, and established a policy of paying both a maternity benefit and complications of pregnancy also. This action must have been taken with a definite knowledge of the costs involved, since the amendment merely reduced the cost to the agency by shortening the compensable period on pregnancy claims.

Therefore the problem is a financial one, and not a medical one.

The Society in its action in 1945 also pointed out that "sickness caused by pregnancy should not be distinguished from sickness from other causes, and it should be equally compensable. In a state such as Rhode Island which even in normal times had one of the highest percentages in the nation for the employment of women there should be no effort made to penalize the female worker who is required to contribute to the Sickness Compensation Fund by denying to her benefits due by reason of her absence from regular employment because of complications arising from pregnancy.

"The offering of a maternity benefit is advantageous from many viewpoints. It would lessen any present tendency to secure benefits during the period of pregnancy unless a complication from the condition actually requires absence from work. It would assure the female worker of compensation at a time when most needed, and when absence from employment is most desirable; i. e., the period immediately before and immediately after confinement."

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DEPARTMENT OF DEFENSE ANNOUNCEMENTS

Military-Civilian Coordination on Medical Reserve Officers ordered into active military service established

Wednesday, December 27, 1950

TO PROVIDE a much greater degree of coordination between military and civilian efforts in utilizing available physicians and dentists, the Department of Defense has established new procedures in selecting medical and dental reserve officers to be ordered into active military service and in developing requirements for these categories of personnel. The system adopted is the result of joint coordination between the Health Resources Advisory Committee of the National Security Resources Board and the Department of Defense.

The new instructions issued by the Department of Defense provide for coordination of military and civilian plans and requirements from two directions — the development of overall requirements and the selection of individual medical and dental reserve officers for active service.

In developing the requirements of the Armed Forces, the Army, Navy and Air Force have been instructed to periodically submit to the Secretary of Defense their proposals for ordering such reservists into active military service. The proposals then will be considered by the Director of Medical Services, Dr. Richard L. Moiling, who will obtain the comments of the Armed Forces Medical Advisory Committee of the Department of Defense and the National Health Resources Advisory Committee of the National Security Resources Board. Final decision on the proposals will be made by the Secretary of Defense.

The National Advisory Committee to the Selective Service System, through its state and local committees, will advise the military services on the civilian essentiality of medical and dental reserve officers of the Army, Navy and Air Force. Those officers who are members of Organized Reserve Units are not to be considered by the National Advisory Committee.

The military departments will be guided by the advice from the Committee. When an officer declared essential as civilian by the Committee is urgently needed by one of the military departments, the final decision in each such case will be rendered by the Secretary of Defense.

THE SECRETARY OF DEFENSE

Washington

22 December 1950

Subject: Call to Active Duty of Reserve Doctors.

The continuing registration of doctors under Selective Service and the continuing trend of applications for reserve commissions place an added responsibility on the Department of Defense in carrying out the President's delegation of authority over reserves.

In addition to its prime responsibility of preparing its requirements for medical personnel, the Department must give due regard to the medical needs of the civilian population. The supply of doctors, dentists, and allied specialists is a valuable resource that exists in limited quantity and for which large military and civilian demand exists. To insure that the military requirements are met with the maximum equitable regard for civilian requirements, I believe it is desirable that the Department of Defense get the benefit of civilian advice before further calls to active duty are made and in no case later calls effective 1 April 1951.

To that end, I desire that the priorities set forth in the Secretary of Defense memorandum of September 7, 1950, entitled "Priorities to be observed in calling medical and dental reserve officers to active duty" be continued and be processed in the following manner:

(1) Periodic proposals for calls to active duty of medical and dental reserve officers will be sent to this Office. On receipt in my office, these proposals will be referred to the Director of Medical Services. The Director will obtain the comments of the Armed Forces Medical Advisory Committee and of the National Health Resources Advisory Committee of the National Security Resources

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DEPARTMENT OF DEFENSE

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Board simultaneously. The National Security Resources Board will be given a period of three days in which to comment. The proposed requirements and the assembled comments thereon will then be transmitted to me for decision.

(2) In accordance with the provisions of Public Law 779 (81st Congress), the President constituted the National Advisory Committee to advise the Selective Service System and to coordinate the work of State and local volunteer advisory committees with respect to the selection of needed medical and dental and allied specialist categories of persons. The regional and local character of these committees makes them an ideal vehicle for the Department of Defense. Accordingly, I have requested them, and the committees have agreed, to appraise the relative availability of each medical and dental reserve in a given geographical area in terms of his essentiality.

To enable the National Advisory Committee to assemble preliminary facts concerning the essentiality of Reserve officers, the Military Departments will transmit to them as soon as possible and not later than sixty days from date of this directive the names of all medical and dental reserve officers not on active duty and who are not members of Organized Reserve Units, requesting that the National Advisory Committee render to the Military Departments an opinion of the relative importance of each reserve officer to his community, together with an opinion of the relative priority of call of each officer.

The Military Departments will be guided by the information thus afforded to them regarding its reserve officers in issuing orders for call to active duty, utilizing for call those officers with the least relative priority, insofar as the professional and other qualifications of the officers meet their needs. After receipt of orders, the individual officer, his employer or responsible parties may request deferment in accordance with established procedures. The comment and advice of the National Advisory Committee will be sought by Deferment Boards within the Military Departments.

Where the individual or his employer believes that the action taken by the Deferment Board is improper, he may appeal the recommendation to my office where the final decision on deferment will be made in such cases.

Nothing in this directive will affect the call to active duty for medical or dental officers who are members of Organized Reserve Units and who have certified their availability for immediate call to duty.

Nothing in this directive shall be interpreted to interfere with the right of individual Reserve officers to volunteer for and be placed on active duty, nor to impede the Military Departments from ordering such volunteers to active duty if their services can be properly utilized. The number of such volunteers placed on active duty within a period will count against the number of Reserves authorized for that period and thus reduce the number required to be called involuntarily.

/s/ ROBERT A. LOVETT
Acting Secretary of Defense

DEPARTMENT OF DEFENSE

Washington 25, D. C.

JANUARY 2, 1951

NAVY MEDICAL OFFICERS HAVE UNTIL JULY 9, 1951 TO REQUEST TRANSFERS TO OTHER SERVICES

Commissioned officers of the Medical, Dental, Nurse, and Medical Service Corps of the regular Navy and Naval Reserve will have until July 9, 1951 to request transfer to another branch of the Armed Services, the Navy announced today. Public Law 779, 81st Congress, which authorized interservice transfer of these personnel of the Army, Navy and Air Force, expires on that date.

Excluded from such transfer are retired officers and commissioned warrant officers of the Hospital Corps, the latter because there is no counterpart for that grade in either the Army or the Air Force.

It was announced, however, that no officer would be transferred without (1) his consent, (2) the consent of the Navy, (3) the consent of the service to which he requests transfer.

Reserves may transfer only to a reserve component and regulars to regular service.

Those transferred will be credited for federal service they have already performed for the purpose of promotion, seniority, and retirement. Transfer of unused leave is also authorized.

CASH SICKNESS PROGRAM

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In the opinion of your Committee the complications of pregnancy should be compensable under the cash sickness act. The question of additional benefits, or maternity benefits, is purely a matter of the availability of finances in the State fund to make such allowances possible.

We have noted in the report of the Administrator of the division of employment security that the title "Cash Sickness Compensation Act" fails to describe properly the type of program.

We are in accord with this observation, and we point again to the action of the Society's House of Delegates five years ago in its comment on the amendments to the act then proposed that the definition should properly be titled "Disability," and the definition should be clarified so that it will be clearly understood "that the *temporary disability* provided for by the program. . . ."

We strongly urge the adoption of the title of the "Rhode Island Temporary Disability Compensation Program." We cannot agree that the word "insurance" should replace the word "compensation," for the cash disability plan is not an insurance program as the public understands insurance, and as insurance contracts operate. The State program is, pure and simple, a cash compensation from a compulsory tax fund to which the worker must contribute, and over which he has little or no control.

Non-Disclosure of Information

The disclosure of some information regarding recipients of benefits of the disability program may be proper. However, we strongly oppose the disclosure of the medical records of any participant in the program without his written consent.

Norms of Disability

The administering agency has developed a table of disability norms for the purpose of estimating the duration of sickness on original and additional claims. The minimum and maximum range of the table has been established to include the age and occupation of the claimant, together with any other complications that may be set forth by the claimant's attending physician. The Committee has viewed this table and it recommends the approval by the House of Delegates of the use of it by the division of employment security in the administration of the temporary disability compensation program, provided a flexibility is permitted by the agency in determining periods of disability beneficial to the health of the patient, and provided that the table is subject to revision by the Society's advisory committee to the employment security division.

Respectfully submitted,

Cash Sickness Compensation Program Advisory Committee

HERMAN C. PITTS, M.D., *Chairman*
ALBERT JACKVONY, M.D.
CHARLES L. FARRELL, M.D.
THOMAS NESTOR, M.D.
JOSEPH L. C. RUISI, M.D.
EDWARD H. TRAINOR, M.D.
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